

Executive Summary

Mental Health, United States, 2002 includes 21 chapters organized into six sections: Looking Back, Looking Forward; Supporting Good Decision-Making; Population Dynamics; Insurance for Mental Health Care; Status of Mental Health Services; and National Mental Health Statistics. Brief descriptions are provided below.

I. LOOKING BACK, LOOKING FORWARD

Arons and colleagues (chapter 1) describe the evolution of SAMHSA's Center for Mental Health Services (CMHS) over its first decade. With the public health model as a framework, descriptions are provided for key CMHS programs; their growth is traced over the decade. Systems of care have been developed, consumer and family perspectives have become fundamental to all programs, and prevention/early intervention approaches have been implemented. Key external events—the Surgeon General's *Report on Mental Health*; the White House Conference on Mental Health; the tragic events of September 11, 2001; and President Bush's *New Freedom Mental Health Commission*—are viewed as critical factors in shaping the current and future agenda of CMHS.

From a broader 40-year perspective, Ray and Kanapaux (chapter 2) analyze the development and evolution of community mental health centers (CMHCs). With their origins in legislation submitted by President Kennedy in 1963, CMHCs grew until 675 were fully funded by the end of the 1970s through a combination of Federal grants for staffing and construction. These CMHCs represented slightly less than half the number originally proposed. With the advent of Federal mental health services block grants in the early 1980s, CMHCs became more closely aligned with State governments, and, in the 1990s, they have become linked to managed care arrangements. Throughout this history, population and service requirements have changed and key movements, such as deinstitutionalization, have had a dramatic impact on program operations. A major recurrent theme over the 40 years has been the necessity to modify operations as funding sources have shifted, often with dramatic

effects on the structure and capacity of CMHCs. These shifting requirements continue to the present. The introduction of evidence-based practices shows promise for stabilizing these linkages.

Wilks and colleagues (chapter 3) look to the future to examine potential changes in the availability of mental health providers. The chapter presents information about the conditions that may influence short-term trends in the number of active providers and trainees in the major mental health service-providing disciplines; the key sociodemographic, system, technological, and psychopharmacological factors that may affect this number; and anticipated short-term changes in the numbers of providers and trainees. The chapter was prepared by representatives of each of the disciplines examined: psychiatry, psychology, social work, psychosocial rehabilitation, psychiatric nursing, counseling, marriage and family therapy, pastoral counseling, and sociology.

II. SUPPORTING GOOD DECISION-MAKING

Because of rapid change and increasing complexity, a need exists to develop a typology through which to understand and organize Nation's approach to the behavioral health care system. Rosenthal and colleagues (chapter 4) have developed such a typology as part of the Substance Abuse and Mental Health Services Administration (SAMHSA) initiative, *Decision Support 2000+*. The typology is based on function (sponsoring, purchasing, and providing care) in contrast to structure; the emphasis is on relationships among functions; and behavioral health care is differentiated from general health care. The typology results from crossing three dimensions: delegation of functions, partitioning the purchase of behavioral health and health care, and transfer of financial risk by the sponsor. When crossed, these dimensions result in 16 different types, nine of which are observed in practice. The chapter describes these nine types, discusses limitations, and outlines a series of policy questions that arise from the typology.

In 2001, SAMHSA's Mental Health Statistics Improvement Program (MHSIP) celebrated its 25th anniversary in conjunction with the 50th Annual National Conference on Mental Health Statistics. Smith and colleagues (chapter 5) describe the past, present, and future of MHSIP. Over the past quarter-century, MHSIP has followed the principles of collaboration and consensus building. Data standards and their implementation have been a cornerstone of this work, but the perspective has been widened to include the consumer view and broader stakeholder participation. The chapter provides a summary of major MHSIP products and initiatives. For the future, major directions include the revision of the MHSIP Consumer-Oriented Report Card and collaboration on *Decision Support 2000+*. Challenges include the ability to influence diverse data initiatives, the informal organizational structure, public-private and specialty-primary care partnerships, funding, and recognition of expertise.

A major need for the field has been the development of appropriate performance indicators to permit benchmarking to enhance decisionmaking about quality improvement and service effectiveness. With these goals in mind, Lutterman and colleagues (chapter 6) report the findings from a 16-State study on mental health performance measures. The study is a joint Federal-State initiative conducted over a three-year period on 32 performance indicators. The project has had major impact on current efforts to collect performance measures through the Community Mental Health Services Block Grant using the Uniform Reporting System. The measures address the dimensions of access, quality, and outcome of care. Findings are presented for each measure, and implications are derived for future work. Each author participated on one or more workgroups over the three-year project period.

III. POPULATION DYNAMICS

Since the tragedy of the terrorist attacks on September 11, 2001, much concern has been expressed about the effects of these events on the prevalence of mental disorders. Galea and colleagues (chapter 7) report the results of two telephone surveys conducted in Manhattan one and four months after these events. The major diagnostic focuses for these surveys were posttraumatic stress disorder (PTSD) and depression. The specific prevalence caused by the attacks was between 7 and 7.5 percent for PTSD and between 9.7 and 10.1 percent for depression. Use of mental health ser-

vices and psychotropic medications also increased after the attacks. Implications of the findings for future disasters are discussed, and limitations of the study are noted.

Dickey and Blumberg (chapter 8) present annual prevalence estimates from the 1999 National Health Interview Survey (NHIS) for major depression, generalized anxiety, and panic attack in the U.S. adult population, age 18 and older. Findings are based on the Composite International Diagnostic Interview-Short Form (CIDI-SF). Over the past 12 months, an estimated 6.3 percent (12.5 million adults) of the civilian, noninstitutionalized population had major depression, 2.8 percent (5.4 million adults) had generalized anxiety, and 2.7 percent (5.3 million adults) had panic attack. More than three-quarters of those with major depression or generalized anxiety experienced some or a lot of interference in life activities. Among those with each type of disorder, about one-third contacted a mental health professional in the past 12 months. Approximately 18.5 percent of adults with any of the three mental disorders were uninsured, compared with 13.1 percent for those without these disorders. Further, 11.7 percent of those with one of the disorders recognized a mental health need that could not be met because of cost; this figure grew to 20.7 percent for those with at least two of the disorders.

From the 1998 and 1999 NHISs, Simpson and colleagues (chapter 9) report findings on the prevalence of problems and service use for attention deficit disorder, developmental delay, learning disability, unhappiness/depression, and overall mental health problems in the U.S. child and adolescent population, ages 5 to 17. Prevalence rates for these problems were 6.6 percent (3.4 million children) for attention deficit disorder; 3.6 percent (1.9 million children) for developmental delay; 8.2 percent (4.3 million children) for learning disability; 3.7 percent (1.9 million children) for unhappiness/depression; and 13.6 percent (7 million children) for overall mental health problems. Considerable comorbidity was observed among the different problems. Approximately 6.5 percent of U.S. children had contact with a mental health professional in the past 12 months, and 6.6 percent received special education services. However, more than 500,000 children (1.1 percent) could not afford mental health care, and more than 4.3 million (10.1 percent) had perceived unmet medical needs.

Very little information exists regarding parental mental illness and its impact on the well-being of children. Nicholson and colleagues (chapter 10)

investigate this issue. From the National Comorbidity Survey, the authors estimate that 68 percent of women and 54 percent of men with a lifetime prevalence of psychiatric disorder are parents. Parallel figures for adults meeting criteria for severe and persistent mental illness are 67 percent and 75 percent, respectively. Looked at from the reverse point of view, among those who are parents, almost half of (47 percent) the mothers and almost a third (29 percent) of the fathers have a lifetime prevalence of mental disorder. Sociodemographic characteristics of these groups are discussed. From a separate survey conducted by the University of Massachusetts Medical School, findings indicate that less than one-fourth of State mental health agencies formally identify adult clients as parents; just over one-quarter have services or programs for adult clients who are parents; and less than 10 percent have written policies or practice guidelines in this area. On the basis of these findings, the authors make a series of recommendations to the States. At the Federal level, no existing Federal programs or policies explicitly consider the circumstances of adults as parents with mental illness. Key Federal programs and legislation, such as Medicaid, the Community Mental Health Services Block Grant, the Adoption and Safe Families Act, the Americans with Disabilities Act, and so on, are reviewed; opportunities are identified for addressing the issue of parental mental illness.

Ellison and colleagues (chapter 11) provide a detailed analysis of the epidemiology and treatment of attention deficit hyperactivity disorder (ADHD). This disorder affects approximately five to seven percent of school-age children, and about 80 percent exhibit persistent ADHD features into adolescence and young adulthood. Approximately 14 percent of youth seen in organized mental health settings are assigned a diagnosis of ADHD. Recent research shows that evidence-based practices are being developed for ADHD. Combining behavioral and psychosocial interventions with medication management is effective for reducing core ADHD symptoms, psychosocial problems, and oppositional behavior in children. An urgent need exists to develop a research infrastructure so that longitudinal studies can investigate medication outcomes that are integrated with psychosocial and behavioral interventions over the lifespan.

Recognizing the need to develop a short screening instrument to identify adults with a serious mental illness (SMI), Kessler and colleagues (chapter 12) tested three different instruments in a two-stage general population convenience sample: the

Composite International Diagnostic Interview-Short Form (CIDI-SF), a modified version of the K10/K6 scales of nonspecific psychological distress, and the World Health Organization-Disability Assessment Schedule (WHO-DAS). Persons with SMI were identified through use of the Structured Clinical Interview for DSM-IV (SCID) and the Global Assessment of Functioning (GAF), and the predictability of the three instruments was assessed. The K6 scale performed the best. However, optimal calibration rules need to be developed in large samples for demographic subgroups because the probability of SMI for an individual with a given K6 score varies with the prevalence of SMI in the population from which the sample is drawn. This calibration work is currently under way in the National Comorbidity Survey Replication (NCSR). Even prior to this calibration, preliminary estimates can be presented from NHIS: The 30-day prevalence of likely SMI is 3.3 percent in 1997, 3.0 percent in 1998, and 2.4 percent in 1999. The preliminary estimate of the 12-month prevalence of SMI from NCSR is 7.2 percent. The demographic risk profile of SMI includes being female, young or middle-aged, unmarried, and of low economic status, and is significantly related to substance abuse disorders. A recommended approach for conducting county-level surveys is described.

IV. INSURANCE FOR MENTAL HEALTH CARE

Finkelstein and colleagues (chapter 13) present updates of earlier estimates for payments and service use for mental health and substance abuse beneficiaries from Medicaid, Medicare, and private sector health plans. Medicaid data are from all claims for 1994 in New Jersey, Michigan, and Washington, and for 1995 in Pennsylvania. Medicare data are from the standard five percent sample for 1995; private-sector data are from a range of employer plans in 1995 that are representative of different industries and regions. The authors provide comparable estimates across the three types of insurance for mental health, substance abuse, and comorbidity, and for children (Medicaid only); costs of specialty and general health care; and comparative costs between the mental health/substance abuse population and a random sample from a population without these disorders, as well as for samples of persons with asthma and diabetes. The authors conclude by discussing planned future analyses.

Parity of mental health and substance abuse insurance benefits with those for physical health care remains a major concern. Hennessy and Barry (chapter 14) present an overview of a parity initiative for these benefits in the Federal Employees Health Benefits (FEHB) program. For this program, “parity” is defined in a fairly inclusive manner and means that a plan’s coverage for mental health and substance abuse must be identical with regard to traditional medical care deductibles, coinsurance, copayments, and day and visit limitations. To implement the 1999 directive that parity begin in 2001, the FEHB program followed three principles: coverage of clinically proven treatments for all disorders recognized in the *Diagnostic and Statistical Manual*, 4th Edition (DSM-IV); extension of parity only to in-network facilities and providers; and expansion of access to in-network providers. In 2000, the U.S. Department of Health and Human Services and the U.S. Office of Personnel Management were charged with conducting an evaluation of the parity initiative. The evaluation has three goals: to assess how parity affects benefit design and management, service access and use, costs, quality, and satisfaction; to examine these effects across plan, provider, and beneficiary subgroups; and to examine the effects of benefit design on the other variables. The evaluation design is quasi-experimental, excludes small plans, and is only partially complete. Early data on benefit design show that the plans being analyzed have implemented parity. Median copayments fell from \$20 to \$10 per visit, and median coinsurance rates dropped from 50 to 15 percent. Results also suggest that plans manage benefits more closely since parity has been implemented.

V. STATUS OF MENTAL HEALTH SERVICES

Levine and Jaffe (chapter 15) present information on antipsychotic medication use in a State hospital system between 1994 and 2000. The report covers all antipsychotic prescriptions written in this 7-year period at the 17 adult hospitals operated by the New York State Office of Mental Health. In this period, the total daily census of these hospitals declined from about 8,500 to 4,500. Between 1994 and 2000, the use of a single typical agent dropped from 70.2 percent of prescribing episodes to 10.3 percent. In the same interval, atypical medications increased from 8.6 percent of medication episodes to 78.7 percent. Coprescribing of more than one antipsychotic medication increased from 11.4 to 38.6 per-

cent of medication episodes. Moreover, the use of augmentation agents increased rapidly during this period. Characteristics of persons for whom antipsychotic medications were prescribed were examined for a single year, 1999. The bulk of the prescriptions were to White males with a diagnosis of schizophrenia or schizoaffective disorder. Other sociodemographic and diagnostic differences were also found. As new antipsychotic agents were introduced, substitution did not occur; total antipsychotic usage increased, and combination strategies grew.

For the first time, a chapter is included on employee assistance programs (EAPs). Masi and colleagues (chapter 16) present an overview of the EAP field. After a brief history, current challenges and opportunities are outlined. A major current challenge is the lack of an integrated alliance to represent the field. Program models and funding mechanisms are also described. Major program dimensions are service configuration, degree of integration, location, and provider type. Funding models include management, colleague, consortium, labor/management, and union. Integration of services is under way, and several developments are outlined regarding managed behavioral health care, work/life services, Web-based services, drug-free workplace programs, and critical incident and psychiatric disability programs. Certification, accreditation, and training practices are reviewed, and the research on EAPs is summarized. Future directions focus on quality improvement, performance measurement, and expanded international cooperation.

Evidence-based practices (EBPs) are an important potential means of quality improvement. Leff (chapter 17) examines the application of EBPs to mental health. EBPs refer to practices that have been tested through specific scientific methods and shown to be safe, efficacious, and effective. The history dates to the original 1906 Food and Drug Act and its amendments, which defined what is safe and efficacious and also set standards of research for acceptable evidence. Much later, quasi-experimental designs and meta-analysis became additional tools to help in defining evidence. Mental health EBPs can originate from several sources, including academic researchers, the Cochrane Collaboration, the Campbell Collaboration, professional/trade organizations, and Federal agencies. Several concerns exist about EBPs in mental health: the democratic concern that all should participate in defining EBPs; the concern that traditional science is too limited; the overstatement concern; the concern that “untested” will be treated as equivalent to “ineffective”; and the concern that

knowing is not equivalent to practicing. For the future, a need is evident for well-ordered science to address the concerns and a governmental infrastructure to provide leadership to the enterprise.

VI. NATIONAL MENTAL HEALTH STATISTICS

Manderscheid and colleagues (chapter 18) provide an overview of mental health services organizations in 2000, together with major national and State trends. In 2000, a total of 4,546 mental health organizations were operating. These organizations maintained 215,221 inpatient and residential treatment beds. Inpatient and residential treatment additions numbered 2,152,874, and additions to less than 24-hour services numbered 4,615,125. Residents of inpatient and residential treatment services on the first day of 1998 numbered 221,216. Total episodes of care in mental health organizations in 2000 grew to 10,741,243. In conjunction with these findings from 2000, the chapter also presents 1998 staffing and financial data, and trend data for selected years back to 1970. Episode data from 1955, the year that marks the beginning of deinstitutionalization for the State mental hospitals, are contrasted with episode data for 2000. Policy implications of the observed trends are discussed, and State maps are presented for 2000 inpatient and residential treatment beds and additions and for additions to less than 24-hour services. All results are from the Survey of Mental Health Organizations and General Hospital Mental Health Services.

The only source of national survey data on the characteristics of persons served in mental health organizations is the Client/Patient Sample Survey (CPSS) conducted periodically by CMHS. Milazzo-Sayre and colleagues (chapter 19) report information from the 1997 CPSS on level of functioning and length of stay for adults served in mental health organizations. On the basis of modified global assessment of functioning (GAF) scores, it is clear that the preponderance of adults served in the inpatient, residential, and less than 24-hour care programs of mental health organizations are quite disabled (GAF scores of 60 or below). With only the exception of persons ages 18 to 44 under care in residential programs or among admissions to less than 24-hour care programs, at least three-quarters of all adults served in all settings are sufficiently disabled to meet the official criteria established by CMHS for adults with an SMI. The median lengths of stay for

inpatient programs mirror the effects of managed care throughout the 1990s. Across all inpatient programs, the maximum median length of stay is about seven days. When analyzed by type of hospital, median lengths of stay are longest in the Department of Veterans Affairs (VA) Medical Centers, where some medians approach 10 days for particular demographic and diagnostic subgroups. In State/county mental hospitals, private psychiatric hospitals, and non-Federal general hospitals, median lengths of stay rarely exceed seven days for any subgroup.

A parallel chapter on children and adolescents who receive services from mental health organizations also has been prepared from CPSS data. Pottick and colleagues (chapter 20) examine the evolution of care as reflected in changes observed between the 1986 and 1997 CPSSs. Both the number and rate of children and adolescents admitted to care rose dramatically between 1986 and 1997. The number admitted grew from about 703 thousand to about 1.3 million during this period, and the rates per 100,000 youth grew from 1,118 to 1,889. Further, both inpatient and ambulatory care increased. The number of children and adolescents admitted to inpatient care grew from about 117 thousand to 286 thousand during this period, and rates per 100,000 grew from 188 to 411. For ambulatory care, the number of admissions grew from 585 thousand to 963 thousand, and the rates per 100,000 grew from 930 to 1,383. For 1997, large sociodemographic differences were noted among the children and adolescents admitted, and clinical characteristics and level of functioning (GAF) varied among care settings. Sources of payment also showed considerable variation.

Duffy and colleagues (chapter 21) continue a series begun in *Mental Health, United States, 1990* that provides periodic updates on the size and composition of the human resources in mental health and the number of trainees preparing to work in the field. The authors of this chapter represent each of the disciplines that make up the mental health field. This chapter provides a description of the demographic and training characteristics and professional activities of psychiatrists, psychologists, social workers, psychiatric nurses, mental health counselors, marriage and family therapists, psycho-social rehabilitation counselors, school psychologists, pastoral counselors, and sociologists. Information includes the total number in each discipline, by year; their sex, age, and racial/ethnic composition; their distribution by State and region; their years since completion of highest professional

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degree; their employment status and setting; and their distribution of work activities. Information on trainees is presented for each of the same disciplines, by year. The authors of this chapter are col-

laborating with the SAMHSA *Decision Support 2000+* initiative to define a new common human resources data set for the mental health field.